ALABAMA BOARD OF HOME MEDICAL EQUIPMENT SERVICES PROVIDERS

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SITE INSPECTION FORM Date: _____ Inspector: _____

REASON FOR VISIT

□ New Provider □ Appeal/Revocation □ Re-Enrollment □ Renewal
□ Re-Inspection □ Random □ Relocation □ Other
Supplier Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Tax ID Number: _____

TYPE OF FACILITY AT THIS ADDRESS

1.) □ Storefront □ Office Suite □ Private Residence □ Branch
□ Warehouse □ P.O. Box □ Commercial Mailbox
□ Other, (Describe): _____

_____

2.) □ Y □ N Does the facility have a complaint protocol:? If No, please explain:

_____

_____

3.) □ Y □ N Is there a visible sign on the front of the facility? If yes, what information is posted?
□ Hours □ Business Name □ Phone Number □ Other

_____

_____

4.) Please list hours of operation: (open at least 30 hrs./week? □ Y □ N)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

RECORDS & TELEPHONE

5.) a) □ Y □ N Are the patient records maintained at this location?
b) □ Y □ N Do these records include supplier delivery slips?
c) □ Y □ N Do these records include supplier maintenance records?

d) □ Y □ N Do these records include physician orders?
e) □ Y □ N Do these records include certificates of medical necessity?
f) □ Y □ N Do these records include services beneficiaries received?
g) □ Y □ N Do these records include equipment beneficiaries received?
h) □ Y □ N Do these records include beneficiary communications (including complaints, beneficiary communications related to complaints, proof of disclosure of Medicare DMEPOS Supplier Standards ("Supplier Standards") to beneficiaries, and patient education documentation)?
If "No" to the above, please explain:_____

_____

6.) □ Y □ N Does this location have a primary business phone number listed in a local telephone directory under the business locations name?
Confirmed by: □ White Pages □ Phone bill
□ Yellow Pages □ Directory Assistance
□ Other:_____

LICENSING

7. For this section, inspector is to actually view and note the following requested information. Verify that the information on all licenses/permits are for this location being inspected.

Expiration Date:

a.) Occupational/Business License _____
Is the license prominently displayed at the location? □ Y □ N
b.) State Business License _____
c.) City or County Business License _____
d.) Certificate of Insurance (Comprehensive Liability Insurance)
(Amount of Coverage:
must be at least $300,000) _____
e.) Board of Pharmacy/Oxygen _____
Permit (if applicable)
Does this location supply oxygen? □ Y □ N
f.) Other (explain) _____

INTERVIEW OF INDIVIDUALS PRESENT

8.) a.) The first person should be the □ PIC □ Owner □ President □ Mngr. □ Administrator

Last Name:_____ First Name: _____

Home Address:_____
City, State, Zip: _____
Home Phone: _____
b.) Others Present: Name:_____
Name _____
Name _____

9.) Is this location a branch office, main office, or sole location? □ Branch □ Main □ Sole Location
If Branch Office, complete the following information:

Main Office: _____

_____

Main Office Phone _____ FAX _____

PIC for Main Office _____

How long has Main Office been operating? _____

INVENTORY

10.) □ Y □ N Does the supplier have inventory in stock?
□ Y □ N Is the inventory maintained in a clean and sanitary condition?
□ Y □ N Is the inventory stored in a dry, well-ventilated area?

a.) □ Y □ N If Yes, is the inventory stored on site?
If No, please provide off site storage address:
Address _____
City & State _____
Zip Code _____ Phone _____

b.) □ Y □ N If supplier does not have any inventory in stock, do they have a contract or credit agreement with another company to purchase HME supplies? (Please attach a copy of the contract or invoice)

□ Copy Attached If Yes, Identify the Company:

Name _____
Address _____
City & State _____
Zip Code _____ Phone Number _____

CONTRACT WITH BENEFICIARY

11.) □ Y □ N Is a copy of the current Supplier Standards provided to all Medicare beneficiaries? (Provide copy of the way this is documented.)

ADDITIONAL COMMENTS

_____

_____

_____

_____